

HAROLD V. SIMPSON II, D.D.S., M.S.D.
DIPLOMATE AMERICAN BOARD OF
PEDIATRIC DENTISTRY

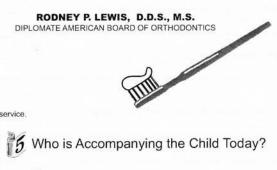
TERRI E . TRAIN, D.D.S., M.S. DIPLOMATE AMERICAN BOARD OF PEDIATRIC DENTISTRY

CANDICE Z. HUTCHESON, D.D.S., M.S.

DIPLOMATE AMERICAN BOARD OF PEDIATRIC DENTISTRY

GAYLE GLENN, D.D.S., M.S.D.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

## Health History Form



Tell us about your Child	₭ Who is Accompanying the Child Today?
Child's Name	Name
Nick Name: Male Female	Relationship
Siblings that we treat	Do you have legal custody of this child? Yes Yes
Child's Birthdate/ / Child's Age	Who may we thank for referring you to our office?
Child's Home # ( )	
SS#	
Child's Home Address	Person Responsible for Account
Company Control Contro	Name
Apt / Condo#	Relationship
State Zip	Billing Address
Biologic Child Adopted	Billing Address
Mother 's Information	City State Zip
Name	Home # ( )
9 397	Work # ()
Stepmother Guardian Birthdate / /	Email
Employer	Primary Dental Insurance
Nork # ( ) Ext	
Home # ( )	Insurance Co. Name
Cellular Phone # ( )	Insurance Co. Address
SS# DL#	
Father's Information	Insurance Co. Phone # ()
	Group # (Plan, Local or Policy#)
Name	Name
Stepfather Guardian Birthdate / /	Address
Employer	
Nork # () Ext	Relationship to Patient
Home # ( )	Birthdate / /
Cellular Phone # ( )	
SS# DL#	Social Security #
Parents' Status Single Married Separated	Employer

	Is this your child's first visit to the dentist?	Has the child ever had any of the following problems?  Y N Handicaps/Disabilities Y N Hearing/Vision Impairment  Y N Developmental Delay Y N Bleeding Disorder  Y N Congenital Birth Defects Y N Diabetes  Y N Hospital Stays/Operations Y N Shunt  Y N Sleep Apnea/Heavy Snoring Y N Asthma  Y N ADD/ADHD Y N Heart Problems/Murmur  Y N Autism Y N Kidney/Liver Problems  Y N Mental Health Issues Y N Tuberculosis/Lung Problems  Y N Allergies Y N Cancer  Y N Allergy to Latex Y N Hepatitis/HIV/AIDS
	Y N Nursing Bottle Habits Y N Thumb / Finger Sucking  Has the child ever had a serious or difficult problem associated  with previous dental work? Yes No  If yes, please explain	Y N Convulsions/Epilepsy/Fainting  If yes, please explain  Please list all drugs the child is currently taking  Please list all drugs the child is allergic to
	Is the child's water fluoridated? Yes No  Is the child taking fluoride supplements? Yes No  Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No  Does the child brush his/her teeth daily? Yes No  Floss his/her teeth daily? Yes No	Are immunizations up to date? Yes No  Child's Physician  Phone # ( )  Is the child currently under the care of a physician? Yes No
	Please check the appropriate boxes below with your prefe  Name and Picture  Picture Only  First name Only and Picture  No Picture or Na  How do you prefer to be contacted for appointment confine  Please check all that apply  phone call to #  e-mail to  text to mobile #  AUTHORIZATION TO TREAT  I understand that the information I have been given is correct it is my responsibility to inform this office of any changes in mabove mentioned patient using restorative or oral surgery to necessary as the dentists deem advisable. I understand	rmation?
	depending upon the time elapsed since the examination and Signature of Parent or Guardian  Date  Office notes:	d the extent of decay.  Relationship to Palient